



Testimony of Martha Peláez

Board Member, National Council on Aging and Evidence-Based Leadership

Collaborative

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Health and Human Services, Education, and Related Agencies

Healthy Aging: Maximizing the Independence, Well-being, and Health of Older

Adults

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Chairwoman DeLauro and Committee members, I appreciate the opportunity to speak with you on behalf of the National Council on Aging (NCOA) about the critical issue of older adult falls and the wisdom of supporting falls prevention.

As an NCOA Board member, I represent the organization's two decades of leadership in falls prevention. NCOA is the national voice for every person's right to age well. Working with thousands of national and local partners, we provide resources, tools, best practices, and advocacy to ensure every person can age with health and financial security. NCOA directs the National Falls Prevention Resource Center,¹ funded by the Administration for Community Living (ACL), which is responsible for educating consumers and professionals about the risks of falls and how to prevent them and supporting the implementation and sustainability of evidence-based falls prevention programs (EBFPPs) and strategies.

Older adult falls are a common, serious, growing public health problem. Falls continue to be the number-one cause of injury, and death from injury, among older adults. The Centers for Disease Control and Prevention (CDC) statistics² are alarming:

- A total of 36 million older adults fell in 2018; 52 million are estimated to fall in 2030.
- Every 11 seconds, an older adult is injured by a fall—such as experiencing a hip fracture or traumatic brain injury—and every 19 minutes, an older adult dies from a fall.
- Each year, approximately 25-30% of adults age 65+ fall, and 20% result in serious injuries, impaired mobility, loss of independence, depression, and social isolation.
- In 2015, more than 3 million older adults received treatment in emergency departments for falls and fall-related injuries, with unintentional falls accounting for 30,000 deaths.
- Fall-related deaths among adults age 75+ almost tripled from 2000 to 2016.

Today in the U.S., there are 54 million adults age 65+, representing 16% of the population.³ Considering that almost 30% of this age group falls, approximately 16.2 million older adults will fall this year alone. This estimate does not include people who fall more than once, whose risk of falling again doubles. Problems with mobility, balance, and loss of muscle strength as people age contribute to the likelihood of falling. In addition, people are living longer with chronic conditions such as heart disease, diabetes mellitus, and arthritis. These illnesses, as well as many of the medications used to treat them, all increase falls risk.

While more than one in four adults age 65+ fall each year, only half share this with their doctors.⁴ The annual direct medical cost for fall injuries is \$50 billion, up from \$38

billion a decade ago, of which 75% is shouldered by Medicare and Medicaid.⁵ The cost of treating the consequences of falls is projected to increase to over \$101 billion by 2030.

Falls are costly, but also preventable. The CDC estimates that between 9,562 and 45,164 medically treated falls could be prevented annually, saving Medicare \$94 million to \$442 million per year.⁶ Effective clinical interventions, evidence-based community programs, new technologies, and clinical-community partnerships must be scaled and fully supported to significantly reduce falls and related injuries. Due to the multi-factorial nature of older adult falls, we recommend three strategies:

Strategy 1: Promote early identification of falls risk factors and coordination of interventions in states and communities. Falls risk, falls, and fall-related injuries should be recognized as a medical condition by health care providers, public health professionals, and the public to increase accurate reporting, compliance with recommendations, and reimbursement for prevention and treatment. The primary risk factors for falls are increasing age, previous history of falls, and female gender, followed by reduced balance and strength, medication effects, presence of chronic conditions, vision and hearing impairments, and fear of falling.

Thanks to research, falls risk factors are widely known, and evidence-based solutions and strategies have been implemented across the country. Yet, insufficient strides have been made in reducing falls in older adults. A 2019 CDC study found the rate of falls and deaths from falls is increasing.⁷ This reflects a lack of awareness and action by individuals to engage in activities that reduce falls risk and a lack of action at the community level, especially in the medical community, to identify risk factors and

refer patients to appropriate treatment. This can be attributed to a lack of reimbursement for assessment and screening, lack of knowledge of EBFPPs available or appropriate referral sources (such as physical and occupational therapists), and competing priorities that discourage falls risk screening and referral.

Falls continue to be the leading cause of injury-related hospitalization among older adults and a leading diagnosis for hospital readmissions. Patients and their caregivers are often unaware of evidence-based best practices when they leave the hospital. Only 12% of patients who follow up with their primary care physician after a fall have the health record of the fall and hospital treatment reviewed.⁸ This lack of communication compounds the underlying issue of identifying the etiology of the fall and referral to appropriate treatment. We support the following solutions to address these issues:

Promote the consistent use of existing screening tools for falls risk: Screening for falls risk factors can occur at the Welcome to Medicare Visit and Annual Wellness Visit. The CDC National Center for Injury Prevention developed the Stopping Elderly Accidents, Deaths, and Injuries (STEADI) initiative, which is the gold standard for falls risk assessment. Every 5,000 health care providers who adopt STEADI produce a savings of \$3.5 billion in direct medical costs over a 5-year period.⁹ STEADI must become the universal tool used for falls risk screening, and reimbursement for its use in clinical practice should be incentivized.

Increase access to evidence-based programs: EBFPPs are based on rigorous research and have been shown to not only reduce falls and falls risk factors, but also health care costs.

- **A Matter of Balance**,¹⁰ is associated with a \$938 decrease in total medical costs per year per older adult participant, driven by a \$517 reduction in hospitalization costs, a \$234 reduction in skilled nursing facility costs, and an \$81 reduction in home health costs.¹¹
- **Stepping On**¹² has been shown to reduce falls by 30% and provide \$134 net benefit per participant, resulting in a 64% return on investment.¹³
- **Tai Ji Quan: Moving for Better Balance**¹⁴ has been shown to reduce falls by 55%, resulting in a \$530 net benefit per participant and a 509% return on investment.¹³
- **Otago Exercise Program**¹⁵ reduces falls by 35% resulting in a \$429 net benefit per participant and a 127% return on investment.¹³
- **EnhanceFitness**¹⁶ physical activity program has been shown to result in a 26% reduced risk of falls, as well as an estimated annual medical cost savings of \$945 per participant.^{11, 17}

Additional evidence-based programs focus on modifiable risk factors, including:

Medication Management: Fall risk increases with the number of medications, as well as therapeutic categories with side effects such as dizziness, balance impairment, and sedation. These effects are reversible through clinical review and modification. HomeMeds¹⁸ offers an in-home medication review and intervention, facilitates medication reconciliation after hospitalization, and decreases adverse drug events that can lead to falls.

Home Modifications: More than 40% of older adults experience some type of disability that limits their performing of at least one activity of daily living such as bathing or dressing. Home modifications and hazard reduction are the most effective

interventions to increase the capacity of an individual to age in place. However, inadequate funding and cost are major barriers. Community Aging in Place-Advancing Better Living for Elders Program¹⁹ is a person-directed, home-based initiative that addresses function, falls risk reduction, and health care expenses. Roughly \$3,000 in program costs per participant yielded more than \$30,000 in savings in medical costs driven by reductions in inpatient and outpatient expenditures.²⁰ The Aging Network also delivers home modification that is not evidence-based but impactful, such as home repairs, hazard reduction, and upgrades. These efforts are funded by formula grants under the Older Americans Act (OAA) Home and Community-Based Services (Title III-B).²¹

Chronic Disease Management: The Chronic Disease Self-Management Program²² helps individuals with chronic conditions manage and improve their health. Studies have shown a \$714 per person saving in emergency department visits and hospital utilization and \$364 per person net savings. Potential savings of \$6.6 billion could be realized by reaching 10% of Americans with one or more chronic conditions.²³ Currently, ACL receives \$5 million annually to implement and improve access to EBFPPs through OAA Title IV competitive grants. Since 2014, these programs have reached nearly 150,000 older adults in 34 states. Many grantees partner with local health care providers for referrals. Five years of data collected by ACL falls prevention grantees show the following:²⁴ 32% of participants reported less fear of falling, 21.6% reported fewer falls, and 10.1% reported fewer injurious falls. Among frequently reported actions, 61% said exercise, 46% talking to family, and 40% changing the home environment. Participants' confidence rose for getting up from the floor, finding a way to reduce falls, protecting themselves from a fall, increasing physical strength, and being more steady on their feet.

Although impressive, EBFPPs are not as widely available as required to meet the needs of older Americans, especially for those living in rural and underserved areas of the country. Not only should EBFPPs be available in every community, but referrals to these programs and other interventions should be associated with the use of the STEADI tool and integrated into the health care referral system to adequately address multiple falls risk factors.

During the pandemic, community-based organizations successfully transitioned to remote delivery of these programs. Preliminary evaluations have shown similar, if not slightly higher, degrees of effectiveness compared in-person programs. Remote programs also reached more older adults, including those coping with lack of transportation or limited mobility. The resources needed for remote programs are vastly different than in-person programs, with stark increases in costs per workshop and per participant due to specialized training for video-conferencing platforms, embedded privacy and security measures, logistical and technical support, and additional staff to ensure safety during program delivery. The benefits of remote programs from an equity standpoint are clear, and it must continue after the pandemic.

The sense of urgency to address falls in older adults requires a significant national investment to scale solutions. As we seek to increase screenings and early interventions, the sufficient numbers and reach of community-based programs are crucial. The annual ACL tables of Title III formula allocations demonstrate how under-resourced the Aging Network is, particularly with respect to preventive health.²⁵

Strategy 2: Establish a coordinated cross-agency federal effort to address falls. Although a number of federal agencies (e.g., ACL, CDC, HUD, CMS) engage in

falls prevention, there is no coordinated and comprehensive falls prevention strategy under the purview of any one single agency. Fully addressing the health and social consequences of falls and implementing best practices require that diverse sectors work together to address this complex issue.

In response to the \$50 billion cost of older adult falls on the health care system, the federal government appropriates less than 1% on direct and indirect responses to older adult falls, and most of that funding has remained stagnant for over a decade. Despite limited funding, a federally coordinated falls prevention national strategy would increase opportunities to leverage resources across disparate agencies and contribute to the sharing of valuable information and systematic solutions that align with agency bottom-line objectives to reduce falls and falls risk in older adults. In the bipartisan 2020 OAA reauthorization, the Interagency Coordinating Committee on Aging was updated to focus on healthy aging and age-friendly communities. We recommend the solutions below as part of a comprehensive strategy:

Support a cross-agency federal effort on falls prevention: This effort should leverage the ACL Interagency Coordinating Committee on Healthy Aging and Age-Friendly Communities to identify Health and Human Services programs and other federal efforts to help change the trajectory of falls and fall-related injuries. The national set of recommendations required in statute should include priority actions to expand and coordinate programs in order to reduce falls risk and improve the health outcomes and independence of people at risk for falls, while reducing the financial burden of fall-related injuries and conditions on individuals, families, and society. It should encompass both promoting healthy lifestyle behaviors that reduce falls risk and creating

environments that make it easier to access, afford, and engage in strategies that reduce falls risk. To ensure older adults, their caregivers, and their communities are aware of the challenges of and interventions for older adult falls, the cross-agency effort should also launch a targeted national awareness campaign.

Strategy 3: Promote federal leadership in research, demonstration, and evaluation. ACL can most effectively enhance services if it maintains a comprehensive and continuous focus on coordinating the knowledge gained through research, field experience, demonstrations, and evaluations. The lack of an integrated and cohesive system of research results in inefficiencies, missed opportunities, and an absence of critical data in federal aging research. In addition, the lack of standardized research indicators and data collection methods makes it very difficult to calculate the impact and outcomes of OAA services.

The largest current OAA program, the nutrition program, began with previous OAA research and demonstration support. Other early programs tested and successfully developed include the long-term care ombudsman program, information and referral systems, elder abuse prevention programs, legal services hotlines, and Aging and Disability Resource Centers.²⁶ There is precedent for this type of authority being housed in the federal government to test new models and ensure efficacy of existing programs. Two such models are the Center for Medicare and Medicaid Innovation and ACL's National Institute on Disability, Independent Living, and Rehabilitation Research.

Funds for the original OAA research and development authority fluctuated over the years, reaching a high of \$54.3 million in 1980 and eventually eliminated a decade ago in a cost-saving effort. In the bipartisan 2020 OAA reauthorization, the research and

demonstration authority in the statute was updated to reflect the needs of today's older adults, the current innovations and challenges of the Aging Network, and iterating specific plans and focus for the creation of a 5-year plan to outline priorities and consultation with experts on aging research and evaluation and Aging Network stakeholders.

Thank you for the opportunity to share our recommendations. The statistics regarding the prevalence and incidence of falls and their consequences are well documented, the key risk factors for falls have been identified, clinical and community strategies and new technologies that address and reduce falls risk have been developed and proven to be effective. However, falls continue to rise and severely impact the lives of older adults. We believe the solution lies in promoting early identification of and intervention for falls risk factors and coordination in states and communities, establishing a coordinated cross-agency federal effort to address falls, and promoting federal leadership in research, demonstration, and evaluation. To achieve this, expanded federal investments are crucial. On behalf of NCOA, I applaud the leadership of Reps. Frankel and Morelle in laying the groundwork with their government-wide FY23 requests.

¹ <https://www.ncoa.org/professionals/health/center-for-healthy-aging/national-falls-prevention-resource-center>

² <https://www.cdc.gov/falls/facts.html>

³ https://acl.gov/sites/default/files/Aging%20and%20Disability%20in%20America/2020ProfileOlderAmericans.Final_.pdf

⁴ <https://pubmed.ncbi.nlm.nih.gov/22704747/>

⁵ <https://www.cdc.gov/falls/data/fall-cost.html>

⁶ [https://www.ajpmonline.org/article/S0749-3797\(18\)31759-8/fulltext](https://www.ajpmonline.org/article/S0749-3797(18)31759-8/fulltext)

⁷ <https://jamanetwork.com/journals/jama/article-abstract/2735063>

⁸ <https://onlinelibrary.wiley.com/doi/10.1111/acem.13938>

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- 9 <http://www.cdc.gov/steady>
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